810 UTILIZATION MANAGEMENT OVERVIEW

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INITIAL
EFFECTIVE DATE: 10/01/1994

Utilization management (UM), often referred to as utilization review, is a methodology used by health care professionals for assessing the medical necessity, appropriateness and cost-effectiveness of professional care, services, procedures and facilities.

UM methodologies include, but are not limited to:

1. Prior authorization (does not apply to emergency services)

2. Concurrent review, and/or

3. Medical claims review (retrospective review).

A. PRIOR AUTHORIZATION

Description. Prior authorization (PA) is a process by which the AHCCCS Division of Fee-for-Service Management (DFSM) determines in advance whether a service that requires prior approval will be covered, based on the initial information received. PA may be granted provisionally (as a temporary authorization) pending the receipt of required documentation to substantiate compliance with AHCCCS criteria. PA does not guarantee payment. Reimbursement is based on the accuracy of the information received with the original PA, on whether or not the service is substantiated through concurrent and/or medical review, and on whether the claim meets claims submission requirements.

PA is issued for AHCCCS covered services within certain limitations, based on the following:

1. The member's AHCCCS eligibility at time of PA request, as confirmed through on-line verification

2. Provider status as an AHCCCS-registered FFS provider

3. The service requested is an AHCCCS covered service requiring PA

4. Information received by the AHCCCS/DFSM PA Unit meets the requirements for issuing a PA number, and

5. The service requested is not covered by another payer (e.g., commercial insurance, Medicare, other agency). NOTE: This is determined by asking the provider, and looking into the member's file for other payer information.

Amount, Duration and Scope. PA must be obtained during regular business hours. For services provided on weekends or state holidays, authorization must be obtained on the next business day, but the attending physician should carefully determine the level of service required.

The general procedures for obtaining a PA number prior to providing an AHCCCS covered service are listed below. Providers may call, fax or mail the PA request to the AHCCCS/DFSM/PA Unit as specified below.

1. Providers must:

   a. Call

      1-602-417-4400 (Phoenix area direct line to the PA Unit)

      1-800-433-0425 (In state direct line into the PA Unit)

      1-800-654-8713 (In state line to AHCCCS switchboard; dial extension 74400 or ask for the PA Unit)

      1-800-523-0231 (Out of state line to AHCCCS switchboard; dial extension 74400 or ask for the PA Unit)

      1-602-417-4000 (Phoenix area AHCCCS switchboard and dial extension 74400 or ask for the PA Unit)

   b. Fax Numbers

      PA-(602) 256-6591

      Transportation-(602) 417-4687

c. Mailing Address

AHCCCS-Division of Fee-for-Service Management
PA Unit, Mail Drop 8900
701 East Jefferson
Phoenix, AZ 85034

2. The following information must be given:

a. Caller name, provider name and provider ID

b. Member/patient name and AHCCCS ID number

c. Type of admission/service

d. Admission/surgery service date

e. ICD-9 diagnosis code(s)

f. CPT procedure code(s) or HCPCS code(s)

g. Anticipated charges (if applicable), and

h. Medical justification.

3. An AHCCCS/DFSM/PA nurse, upon receipt and assessment of information provided, will issue to the calling provider an approval, a provisional PA number or notify them of a denial of coverage.

4. AHCCCS DFSM/PA generates a PA confirmation letter of approval, provisional approval (awaiting additional information), or denial of coverage, which is mailed to the provider the next business day.

   For all requirements related to the grievance system, refer to Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

5. PA is <u>not</u> required for FFS members receiving services from Indian Health Service (IHS) providers and facilities. A non-IHS provider or facility rendering AHCCCS covered services must obtain PA from the AHCCCS/DFSM/PA Unit for services specified in Policy 820 of this Chapter when scheduling an appointment or admission for the FFS member.

B. CONCURRENT REVIEW FOR HOSPITAL SERVICES

Description. Concurrent review may be performed on admission and at frequent intervals during acute inpatient hospital stays. Reviewers assess the appropriate usage of ancillary resources, levels of care (LOC) and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for continued stay and evaluates quality of care.

1. Concurrent review is provided by an AHCCCS contracted review organization that employs licensed health care professionals to perform reviews.

2. Concurrent review begins when the AHCCCS/Division of Fee-for-Service Management/Prior Authorization (AHCCCS/DFSM/PA) Unit notifies the contracted review organization of the admission or need for review.

3. Concurrent review is generally initiated by the next business day and continues at intervals appropriate to patient condition, based on the review findings. During review, the following are considered:

    a. Necessity of admission and appropriateness of service setting

    b. Quality of care

    c. Length of stay

    d. Whether services meet the coverage requirements for the eligibility type

    e. Discharge needs, and

    f. Utilization pattern analysis.